COVER SHEET

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AUTHORS: **Glenn Gardner**, Royal Brisbane and Women's Hospital and Queensland University of Technology, Australia

Robert Cook, The Canberra Hospital and University of Canberra, Australia

Address: Professor Glenn Gardner (corresponding author)

Centre for Clinical Nursing

Royal Brisbane and Women's Hospital

Butterfield St

Herston QLD 4029

AUSTRALIA

Telephone: +61 7 3636 5395

Fax: +61 7 3636 1557

E-mail: ge.gardner@qut.edu.au

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Abstract

Drawing from an interpretive study this paper reports on an investigation into the way that patients receive information about having a surgical wound infection. The study findings indicated that patients often struggle to gain this information and health professionals use a range of strategies to avoid rather than engage the patient in discussions about their infection. A sociological analysis of this avoidance draws upon the literature pertaining to issues of power/knowledge, shame, and reluctance to engage in potentially distressing interactions. The findings also indicate that considerations of the success of surgery can relate more to the technical aspects of the operation rather than the patient health outcomes. This study demonstrates the clinical relevance of interpretive research and shows how this approach can produce knowledge to inform health service and patient care practices.

Key words: health care associated infection, surgical site infection, multi-resistant infection, power/knowledge, shame

Biographical note:

GLENN GARDNER is Professor of Clinical Nursing and Director of the Centre for Clinical Nursing at the Royal Brisbane and Women's Hospital and Queensland University of Technology. She has a PhD in sociology and anthropology, and has published on topics related to health care related infection, acute care nursing, and the experience of illness. She is also Editor of *Collegian*, the scholarly journal of the Royal College of Nursing, Australia.

ROBERT COOK is a registered nurse with an honours degree in applied psychology. He works as a research assistant in The Canberra Hospital & University of Canberra Research Centre for Nursing Practice in the Australian Capital Territory.

Telling accounts of wound infections: Avoidance, anomaly and ambiguity

Introduction

Health care associated infection of surgical wounds is a significant problem in hospitals worldwide. It has been demonstrated that surgical site infection (SSI) leads to extended hospital stays (Kirkland, Briggs, Trivette, Wilkinson and Sexton, 1999; McLaws, Irwig, Mock, Berry and Gold, 1988), increased health care costs (Kirkland et al., 1999; Plowman et al., 1999), increased risk of mortality (Kirkland et al., 1999), and increased suffering for the patient and family (Gardner, 1998).

Whilst there is an extensive and increasing amount of information from research into the epidemiological and microbiological dimensions of health care associated SSI, there is less knowledge about the human experience of this event. The scant literature that is available indicates that for the person entering hospital to undergo a surgical procedure, the infection of a wound with antibiotic-resistant organisms interrupts the expected progress towards health recovery and leaves the person to cope with the disturbing manifestations of a new disease (Gardner, 1998).

In this paper we report on a study that examined the narratives of surgical patients in order to explore one aspect of this illness experience, that is the event of finding out about a SSI. In so doing we will demonstrate the clinical relevance of interpretive research and demonstrate how this approach can produce knowledge to inform health service and patient care practices.

Methods

We conducted a sociological, interpretive study that was informed by the methodology of 'interpretive interactionism' (Denzin, 2001; Denzin and Lincoln, 2000). Denzin (2001) claimed that the interpretive process links an individual life and its problems to a public, historical social structure. Hence this approach provided a theoretical framework to investigate SSI as problems experienced by health care consumers and the relationship between the experience of these problems and the systems of health care that are set up to address them. Furthermore the methodology advocates a research approach that aims to

connect the meaning-making experiences of participants to a cultural criticism of the public structures that represent those experiences. It is biographical and contextual in that the narratives of these experiences are interpreted, as they are located in the natural social world.

It is this aspect of interpretive interactionism that highlights its value for research into issues of health and health care in that it makes available the participants' lived experience of health care and allows the researcher/s to evaluate how these experiences are influenced by health service delivery and health outcomes.

Data collection and analysis

The study was conducted in a region of Australia that incorporated both urban and provincial communities and covered a population area of over 3,000,000. Recruitment of research participants was achieved through a community nursing service that operated across these environments. In-depth interviews were conducted with a purposeful sample of 20 participants. The sampling selection criteria for client participants were: people with SSI, discharged from hospital into the care of domiciliary nursing, who were able (according to age and mental faculties) to give informed consent to participation. In order to gain an in-depth understanding of people's experience of health care associated SSI, interviews were conducted to the point of accessing multiple experiences of emerging themes. Thus the sampling method was both theoretical and purposeful (Patton, 2002).

Data analysis was an ongoing process throughout the project and commenced with the first interview transcript. The analytic techniques relied upon interpretation of narrative data through an active and continuous process of study and review to locate and explicate the essential meanings of the human consequences of health care associated SSI. This process included drawing upon the literature to then bring interpretive meaning to the emergent themes to produce new knowledge. In this report participants' voices are used in selected narratives to both illustrate the theoretical outcomes of the study in relation to the event of finding out about a health care associated SSI, and to evoke for the reader the human dimension of this illness experience.

Findings

When people enter hospital for surgery there is an expectation of an illness trajectory that has a period of convalescence followed by a conclusion of illness and a return to health. The event of acquiring a wound infection in the hospital is an interruption to this expected course of recovery. An unanticipated complication of illness and the resultant prolonged suffering and disability is a major trauma for the patient, a trauma that requires sensitive consultation with health carers. For most of the participants in this research, finding out about the infection was itself a traumatic and inconclusive event.

Pete was a 45-year-old mechanic who acquired an antibiotic resistant infection following abdominal surgery. Pete was asked how he knew about the infection.

> *Pete*: I could smell it for a start and then all the ooze… I could see, it wouldn't heal. But that doctor… he just pulled the top part of the stitch out and put his finger in there and opened it up with his finger. He had a glove on, he just pulled it open again. I just about hit the roof.
>
> *Researcher*: Did you know that was going to happen?
>
> *Pete*: No. He said nothing, just, 'yeah that's got infected' and opened it. I thought I was going to die. He just shoved his finger in there, I wouldn't even put me finger in an engine and do what he did. But then... it got worse over the weekend.

In describing this incident Pete was very agitated. The memory of this treatment six months later still made him feel angry. The first indication that he had regarding the infection was from his own senses: 'I could smell it... and then all the ooze'. The involvement of medical staff in contributing to his knowledge was the point when the doctor opened the stitches. This was a significant event for Pete. Firstly, the action offended his sense of the right way to perform this procedure: 'he put his finger in there… and opened it with his finger'. His judgement of this action is very strong. Pete, as an engineer, would not do this to an engine and yet he witnessed a doctor doing this to his body. The fact that the doctor used his finger is important to Pete. Engineers use tools in their work and doctors similarly use tools: he repeats the word *finger* several times as though the same procedure with a tool would have been less of an assault, more acceptable. The unexpected element of this action

provoked strong anger from Pete; he had no time to process the news that he had an infection before the wound was opened, so that it was a dual assault linked closely in Pete's narrative.

Mrs Holden echoed this sense of indignation. She was asked how she found out about having an infection in her wound.

> *Mrs H*: Just by hearing them talking about it. Before I knew how bad the infection was my daughter waited to catch up with him [the surgeon] one night. He was one of those doctors who just popped in to have a look at you and out and you don't get a chance to say what you want to say. The junior ones don't tell you much either, they're only talking to one another.
>
> *Researcher*: Did the nurses talk to you about the infection?
>
> *Mrs H*: No.
>
> *Researcher*: How did you feel about having an infection?
>
> *Mrs H*: I just felt I was a guinea pig to be honest.
>
> *Researcher*: Did you want to know what was going on?
>
> *Mrs H*: I'd prefer to know. I'd like to know a lot more than they tell you. You're left guessing. So Beryl [her daughter] confronted him one night and that was when a bit of information came out about an infection.

Mrs Holden's story is that whilst the doctors and nurses knew about the changes in her body she remained ignorant. The doctors came in and out of her room, talked about her amongst themselves, she was not included. In feeling like a guinea pig she was passive and helpless in the process. Guinea pigs are subject to scientific experiments, they are acted upon by others. The guinea pig's well-being is secondary to a higher good. Mrs Holden talked about the secrecy surrounding her infection: 'they know more than I know'. Her daughter had to intervene to gain information from the surgeon.

Secrecy was also an issue with Les. When the researcher asked him how he thought the hospital system could have been more helpful his response was related to information about his SSI.

> *Les:* By not giving me the infection in the first place. But if they had gotten to it sooner, when I first started complaining about it, they might have been able to stop it spreading.
>
> *Researcher:* Were you complaining about it [the infection] when you were in the hospital?
>
> *Les:* Before I came home after the first operation I said that I had a high temperature. And I said that I was a bit sore and they said 'oh that's just an after-effect of the operation'.
>
> *Researcher:* And what did they say about your temperature?
>
> *Les:* It didn't register as being high. But I felt... [he paused and seemed to search for the right word]
>
> *Researcher:* You felt hot?
>
> *Les:* Yeah, they reckon it was just me imagination. I mean, I didn't know any better. Thinking back I should've grabbed them round the throat and said, 'look, look, you know there is something wrong. This is not the way I normally feel'.

Les's narrative indicates that there was no significant conversation with the hospital doctors or nurses about the nature and consequences of his infection. Eventually a continuous and persistent questioning of medical staff combined to provide Les with a knowledge of sorts about his disease. His own knowledge of his body was outside of the discourse of medical science and therefore had no authority. When Les complained of feeling hot during his initial hospitalisation, his temperature did not register as such and therefore he was not believed. A minor technology of medical science, the humble thermometer, had more credibility and authority than Les himself, and his knowledge of his body was written off as imagination.

When Paul was being discharged following surgery his lower leg was still bandaged and very swollen.

> The sister said she didn't like the look of it [his leg]. She wanted the doctor to remove the dressing and have a look before I left... he wouldn't do it. But the nurse knew, she just said... 'you'll be going home today Paul... with a small hole in your leg'.

Paul was discharged after two weeks in hospital. He was told that his leg was healing and to start weight-bearing. He was noticing blisters and weeping around the wound but was unable to get any action.

> The weeping was coming through, there was a boil starting to come up there… two days later I couldn't walk on that leg again. It just flared up. I got back over to the emergency section in the hospital and they took me through for x-rays and that's where I got the word out of the nurses, in that section. They said 'You've got infected tissues there'. They were the first ones to let this out and the doctor in the meantime he didn't want to know me, no other doctor wanted to come near me.

The dominant feature of this narrative is the sense of frustration that Paul experienced. The eruption of 'boils' and weeping from his wound was indication enough for him that there was a problem. But each of the interactions he had with the medical doctors was characterised by avoidance in discussing the infection and the instigation of further treatment. The nurses in this narrative are situated between Paul and the doctors. The ward nurse knew he had an infection and in an indirect way attempted to have the doctor make the diagnosis. But ultimately she too entered the pattern of silence and evasion with the statement 'you'll be going home today Paul... with a small hole in your leg'.

Some of the participants in the study were informed that they had a SSI. Four of the participants were informed by a doctor or nurse that their wound was infected. The remaining participants however were either not given any information or accumulated information through persistent questioning of health professionals. To have known about the infection was important to these participants. This is demonstrated by the various

means they used to acquired more information, including taking the initiative through persistent questioning.

The repetition across the narratives of not receiving full and meaningful information raises the question of how to gain an understanding of this event. The patients who participated in this study were in different hospitals, some were patients in private hospital and others were in state hospitals, they represented a range of age groups and educational levels, and the surgical procedures varied across a range of medical specialities. The one thing they had in common was the obvious one – they were all patients in hospital. Understanding therefore may be achieved through an analysis of the social relational aspects of hospitalised care.

There is a large field of sociological literature that looks to medicine's control of knowledge as an instrument of power. The class position of medicine, it is claimed, is a power base that is reinforced by its access to, and definition of, the needs of its consumers (Morgan, Calnan and Manning, 1991; Turner, 1987). The accumulation of scientific knowledge that relates to the diagnosis and treatment of disease defines these needs.

Michel Foucault (1977) observed a close relationship between power and knowledge, a relationship that he expressed as a unity:

> … [P]ower and knowledge directly imply one another… there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977: 27).

Foucault isolated 'the body' as the essential component in the exercise of power in social life. This he refers to as the 'political technology of the body' (Foucault, 1977: 26), which is the expression of biological knowledge as an instrumentation of power. This, according to Foucault, produces a view of the body as something docile, 'the body that is manipulated, shaped, trained, which obeys, responds, becomes skilful and increases its force' (Foucault, 1977: 136). Foucault claimed that political technologies are the mechanisms by which power operates, rather than particular institutional or state apparatus. However, he did critique the power of medicine within this locus of study.

Bryan Turner (1987), in his analysis of professions, argued that the specialised knowledge of the professional creates the basis for prestige and social distance between the professional and the client, a social distance that is defined by the exclusion from access to the specialist body of knowledge. In locating his analysis specifically within medicine, Turner claimed that:

> The doctor has a social monopoly of expertise and knowledge which is the very basis of the professional claim to a privileged status in society. The doctor's authority in the consultation depends to a considerable extent on this monopoly of knowledge (Turner, 1987: 50).

This echoes Evan Willis' (1983) conception of 'medical sovereignty', wherein medicine is seen to dominate relations between the health care sector and the general public. According to Willis, doctors have become 'institutionalised experts on all matters relating to health' (Willis, 1983: 3).

This line of thought can provide a way of understanding the lack of engagement between doctor and patient in providing information about a SSI. According to this interpretation the doctors act in accordance with their professional role and draw upon their position to control access to information. However, the professional role of nursing is somewhat more problematic in terms of an explanatory framework for understanding the experience of the patients in this study. Whilst nursing does accumulate and exercise discipline knowledge, this knowledge is not imbued with the social and political power that accompanies medical knowledge (Manias and Street, 2001; Wicks, 1995). Therefore an additional understanding, and one that encompasses both medical and nursing management of these patient care issues, can possibly be gained by examination of the nature of the disease itself and reframing SSI as an iatrogenic event.

Ivan Illich (1976) was one of the early writers who critiqued the concept of iatrogenesis. Illich posited that professional medicine was a 'major threat' to health and went on to described the professionalised power base of medicine as being at the roots of an *iatrogenic* epidemic in that medicine has given its practitioners the ability to cause as well as cure disease. Health care associated SSI may well be the definitive iatrogenic disease – the disease occurs at the hands (sometimes literally) of the doctor or nurse. The issue of

who ultimately caused the infection is in most cases unable to be addressed. In the course of a surgical experience the patient is exposed to the hands of many nurses, doctors, and often medical and nursing students. This surgical team is a broad and diffuse group of health professionals. But when a complication occurs it is usually the surgeon to whom the patient looks for an explanation.

This explanation is informed by social and historical context of medicine's domination of the microbial world. From the nineteenth century with the discovery of asepsis, through to and beyond the 1940s with the discovery of antimicrobials, medicine has claimed dominance over pathogenic organisms. By co-opting science as its knowledge base, the medical profession was able to convince the public that it controlled a valuable commodity that was essential for saving lives and curing disease. Morgan and her colleagues (1991) argued that the medical profession's adoption of the germ theory of disease led to a shift away from patient-centred medicine towards a system that reduced patient involvement and created patient dependence. Medical interventions such as surgery became safer, thus increasing patient dependence through an increase in the success, mystique, and power of medical knowledge.

A health care associated SSI is therefore a medical anomaly. It produces a bacterial infection that cannot be cured and successful surgery that results in a disrupted body. A chronic wound resulting from SSI, according to the discipline's own standards, indicates failure at both the professional and individual level of medicine. The superiority of medical science and skill is undermined and medicine no longer dominates pathogenic bacterial organisms. In the face of multi-resistant organisms the medical armoury of curative treatments is impotent. Coupled with this impotence is the question of culpability. Cross-infection indicates a breakdown in medical and nursing practice.

Together, these factors threaten the authority and regard of medicine, or specifically the surgical team, and may trigger what Donald Nathanson (1992) described as the polar opposite of pride – shame. Nathanson (1992) described shame as a primary force in social and political evolution. Shame, he claimed, is an emotion associated with incompetence, failure, or inadequacy. More recently, psychologist Nancy Eisenberg (2000) has described shame as being centred on the self, as being preoccupied with others' opinions, and as

being likely to arise from non-moral situations or issues, for example failures of performance.

The notion of shame has received scant attention in the health related literature since Lazare (1987: 1656) noted that '[t]here are physicians who are particularly shame-prone over their need to see themselves as perfect and in complete control in their practice of medicine'. Shame has been discussed more recently regarding health care safety issues (Davidoff, 2002) and as a barrier to reporting of adverse events (Kaplan and Barach, 2002). While not directly referring to shame, Krizek (2000) made a significant point reporting on the difficulty that surgeons have with telling their patients the truth about adverse events and medical errors. Importantly, many of these authors note that strategies used to dissipate the emotional consequences of shame are avoidance (Lewis, 1992; Nathanson, 1992) and silence (Davidoff, 2002).

Whilst shame may well play a part, the main issue for the patients in this study was that both doctors and nurses minimised the opportunity to engage in a full and meaningful discussion about the new and unwelcome diagnosis of infection. The capacity of doctors to avoid a discussion with the patient regarding the infection in their surgical wound can be seen as a manifestation of medical power. In Pete's experience the doctor, by virtue of his position, was able to combine the action of removing the suture with relating the information about infection, a focus that enabled him to avoid a talk-based interaction. With Mrs Holden the doctors and nurses talked over and around her, leaving her out of the discussions about her condition to the extent that she 'felt like a guinea pig'. These examples of avoidance by a doctor or nurse of patient consultation with a clear explanation about the SSI can be interpreted as a strategy used by these health professionals to explain away, ignore or deny this iatrogenic event. The (possibly) unintended consequence is that for the patient, this was perceived as a disturbing and confusing development and served to increase their suffering.

Early writers in the field of medical sociology offer a different framework to explain avoidance. Clinical justification and experience of patients who 'go to pieces' have been used as reasons for avoidance, although this justification is more likely to be based on doctors seeking to avoid repetition of one or two traumatic incidences rather than on broad and repeated experience (Oken, 1961).

Further studies (Glaser and Strauss, 1965) found avoidance to be a factor in investigating doctor/nurse-patient interactions on the topic of awareness of dying. The reasons for this avoidance included health professionals' imperative to maintain patients' trust in a 'fictional future biography' (Glaser and Strauss, 1965: 33) and the inability of some doctors to handle the communication skills of making a complicated illness understandable. This finding has been supported in subsequent research (Fallowfield et al., 2002). A pervasive rationale throughout these studies was related to the fact that doctors and nurses commonly experienced distress and trauma in coping with the consequences of conveying bad news.

Hence there are a number of factors that potentially contribute to the health professional's avoidance of a direct consultation with patients about the nature of disease. In this study the avoidance on the part of doctors supports the extensive literature relating to medicine and the use of power to maintain professional dominance and authority. There is less consideration in the sociological literature of hospital nursing as a focus of inquiry. There has however been some attention to nursing in relation to its domination by medicine (for example Willis, 1983; Turner, 1987). Further to this there is some indication that nurses participate in the play of medical power (Stein, Watts and Howell, 1990) and believe that they lack the professional power to engage patients about the nature and prognosis of their illness/condition (Parker and Gardner, 1991). Consideration of these factors together with the experiences of the patients in this study indicate that nursing may well be complicit, albeit passively, in avoiding engagement with patients on the nature of their SSI. Considering that nurses are constantly in attendance to the patient this study highlights the need for further research into the conditions and practices of hospital based nursing.

<u>The operation was a success but…</u>

A further aspect of finding out about infection is the separation of the operation from the total surgical experience. This is the result of a reductionist approach to surgical care, or as some authors describe the process, an understanding of the person through reference to the underlying anatomical mechanisms (Engel, 1977; Good, 1994). This is a way of thinking that is central to the medical gaze and conforms to a notion of the body as a machine. Within this framework, the technical aspect of the operation gets the body parts working again

without the rest of the body being affected. What happens thereafter is of less importance and, as the experiences of the participants in this study demonstrate, of less interest to the surgeon.

Mrs Stone was a 76-year-old woman of Eastern European origin; she lived alone in a retirement village. She was relating a description of her recovery phase following knee replacement surgery.

> Operation was very satisfactory, yes. It's just after that. I came home but, it didn't look right. When I came home the community nurse came to bath me and she said 'that looks infected'. And so we called the local doctor and he said 'that's infected' and they put me back to hospital.

The researcher asked Mrs Stone if there had been any sign of infection whilst she was still in hospital.

> *Mrs S*: Yes, it was all blue and red and swollen... and was very painful and hot, just burning like fire. And they give me, sixteen tablets, antibiotics a day. Sixteen. That's all they did.
>
> *Researcher*: Did they tell you it was infected?
>
> *Mrs S*: Well they didn't say, but if it wasn't infected why would they give me the tablets? Well some of them said, 'oh it's common, it happens, you know, it's inflammation'. But what is inflammation? Inflammation is infection. Isn't it?
>
> *Researcher*: Were the staff taking your temperature and looking at the wound?
>
> *Mrs S*: Not much really. The doctors came, I mean, they only came when I was complaining. They came to the bed, and they just looked from there [laughter as she points to spot about a metre away].

Mrs Stone separated the operation from the recovery phase. Her description suggests that that Mrs Stone had an infection and was being treated with multiple antibiotics before her discharge. However, the presence of an infection was not communicated to her and the clinical signs were dismissed as a common occurrence – not infection but inflammation.

When the doctors came to see Mrs Stone in response to her complaints they observed her from the end of the bed. The medical gaze captured Mrs Stone as a body, laid out on the bed open to their scrutiny. For Mrs Stone this behaviour was a farce – she saw as an absurdity a medical examination conducted from a distance and a medical consultation that contained no personal interaction: 'They came to the bed, and they just looked from there'.

Mrs Green had severe pain and swelling in her knee following surgery, and had discharge from one end of the wound. She was describing the pain she experienced. The researcher asked her if she thought this meant that something was wrong.

> Well I said to him [the surgeon] it shouldn't be that sore and he said 'well if you saw what was done inside with all the chipping and sewing I'd expect you to be very sore'. And then when I left he said to me 'now I want you to behave yourself, I've fixed your knee, don't get into any car accidents or anything'.

The primacy of surgery over any other concerns is dominant in this description. The surgeon rationally explained Mrs Holden's pain with reference to the complexity of the surgery. She was cautioned by the surgeon to be careful following discharge. The fact that Mrs Holden by this time had the manifestations of a surgical infection, such as pain, swelling, and a wound discharge, was not a consideration for the surgeon. He was primarily focused on the mechanical aspects and protecting the success of the surgery.

Libby's life had been disrupted for two years as a result of an abdominal SSI, and her anger was directed at her surgeon. In the following extract Libby expressed powerlessness and passivity. She was unable to gain information and action from her surgeon, nor was she able to challenge the surgeon about his treatment.

> They said they sent a swab away to get tested the first time I was in hospital and it came back and it was Golden Staph. Well the doctor won't talk to me much at all. I don't know what it is, I've been told it's an infection and there is nothing that can kill it.

Flora had received a diathermy (cauterising) burn during surgery on her back that became infected.

> After I'd had the operation the nurses kept saying to me ‘what's this thing on your back?’ And of course I can't see my back. And they said ‘have you got a birthmark?’ and I said ‘no, not that I know of’. Anyway it was a piece of dead flesh from the operation. And because I was a private patient Doctor Reed came and he had a look. And he said, ‘oh, after twelve years and seventy-five operations a year this is the first [burn]. Anyway he was going on holidays so he came in on the Wednesday and said ‘you can go home, sister can take the clips out and you can go home’. Anyway sister came, she just turned round and she said ‘I don't like this at all’. Went and got this other doctor. And I sort of turned my head and he was just shaking his head. He couldn't go over the specialist. So they had to send me home.

The surgeon’s job was finished, he was going on holidays, so Flora was discharged. There is evidence in Flora’s narrative that the nurse and the registrar did not agree with the surgeon’s decision, but ultimately it was his decision that prevailed. A feature of Flora’s narrative is that the complications that surrounded her surgery were less important than the surgery itself. The fact that she was subsequently readmitted after a short period at home illustrates the inappropriateness of this approach to surgical care. Her confusion and lack of knowledge about the problems with her wound served to reinforce her suffering. The only information she had was that she was an aberration; her case deviated from the surgeon’s normal performance of surgery.

For the participants in this study, the hospital doctors, including the surgeon, defined the hospitalisation for surgery for these patients as successful. The patients took this cue from the medical discourse and repeated the curative outcome of their surgical experience. The examples provided in this report are both evocative and representative (Tyler, 1986) of the experiences of other participants who were involved in this study.

The discourse of medicine that defines health, illness, cure, and disease (Cheek, Shoebridge, Willis and Zadoroznyj, 1996) is silent in the face of a ‘successful’ surgical outcome that is complicated by an antibiotic-resistant SSI. Whilst the causal model of disease is able to incorporate the event of a SSI, there is no curative or therapeutic response; the infected patient must be moved out of hospital (or separated from other patients) and antimicrobial drugs are ineffective. The considerable social prestige and economic success that comes with being a surgeon is dependent upon the curative, or at least death-preventing, outcomes of surgical

interventions. The occurrence of a SSI is an anomaly to 'successful' surgery. Consequently, as demonstrated by the experiences of the patients in this study, the medical response is to consider the event, and therefore the patient, an aberration, a bothersome deviation from the normal outcome of successful surgery.

Arney and Bergen (1983) described how the play of medical power has in the past effectively incorporated the *anomaly* into an object of medical inquiry and replaced it with the *chronic patient*. The anomaly, which they described as 'the handicapped and disabled' (Arney and Bergen, 1983: 1), became subjected to the medical gaze and as such was redefined and medicalised. This, according to the authors, enabled the medical man (sic) to demonstrate the compassionate responses that were the moral imperative associated with medical responsibility and status. The medical approach to other spheres of life, such as childbirth, alcoholism, and homosexuality, also resulted in these behaviours and activities becoming objects of the disease model. Whilst medicine had traditionally incorporated and redefined the anomaly, it also had an aetiology/curative model of response. If the 'disease' was unable to be cured it was usually amenable to hospitalisation, drug therapy, or psychotherapy.

It has come to pass that, in the latter part of the twentieth and beginning of the twenty-first centuries, medicine, or more specifically surgery, is confronted with its own anomaly, one of its own making. This poses a paradox for these surgical patients – the operation was a 'success' but the wound, which is part of the surgery, is not healing. There is little if any discussion from the hospital staff that may explain the paradox, and so the patient is left with making sense of a 'successful' medical intervention that has resulted in a new and indefinable disease. This creates a state of confusion and ambiguity for the patient that increases as the course of their new disease unfolds. One of the consequences of health care associated SSI, therefore, is the human dimension of living in a state of ambiguity with and through a body that is suspended between health and illness.

Conclusion

Medical science has provided the conditions that cause health care associated, antibiotic resistant infection and the impotence in curing the condition. The health care system provides the structural and professional systems that are responsible for treatment and care of the patient, or, in the words of Denzin (2001), the structure of the health care system has created the conditions for the experiencing and expression of personal troubles. This study

has examined and demonstrated how these conditions are created and how the experiences are expressed.

As consumers of health care, the participants in this study embarked upon the surgical experience with an expectation of achieving an improved state of health. The infection of a wound with an antibiotic-resistant organism interrupts the expected progress towards health recovery and leaves the person to cope with the disturbing manifestations of a new disease. In this event there is an (unmet) expectation that medical expertise is available within the institution of the hospital to diagnose and either cure the disease or mitigate the ensuing suffering.

The social position of power and prestige that medicine has garnered over the past one hundred years has resulted in part from the discipline's adoption of empirico-science as its knowledge base and the causal/curative model of health care as its practice base. This model assumes disease to be fully accounted for by deviations from the norm of measurable, biological variables (Engel, 1977). The biomedical model embraces reductionism through its separation of the person from the dysfunctional part, an approach that assumes the mind and the body are separate and reducible entities. It is from this formative cultural background that the hospital doctor confronts the event of a patient with a health care associated SSI.

Analysis of the experiences of the participants in this study indicates that rather than engaging the patient in discussion about the SSI, the actions adopted by the doctors and nurses in the surgical team resulted in an avoidance response. We have proposed a number of possible interpretations of this avoidance response.

We have also argued that a health care associated, antibiotic resistant SSI is anomalous to the curative functions of surgical intervention. Through the model of practice that reduces an illness to its anatomical level, the patient is also reduced to a problem that can be solved through surgery. This process is central to the medical gaze, which is the perceptual extension of the medical discourse. In the event that surgery has corrected an anatomical problem the process is deemed successful and an infection of the wound is perceived as tangential to the success of the operation. A view that is at odds with the patients' own experience.

The discursive practice of medicine that avoids and discounts the emotional and physical impact of a SSI contributes to the state of confusion and ambiguity that characterises the experience of the patient. Consequently, hospital staff remain unaware of the human suffering that results from health care associated infection and the ways in which inadequate communication with the patient contributes to this suffering.

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